ADDENDUM 1
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IN THE CIRCUIT COURT OF
MADISON COUNTY, TENNESSEE
AT JACKSON, DIVISION I

JON HALL,

Petitioner,

vs. No. C00-422

STATE OF TENNESSEE,

Defendant.

HEARING ON POST-CONVICTION RELIEF PETITION

NOVEMBER 4, 2002

AMY MAYS
OFFICIAL COURT REPORTER
MADISON COUNTY CRIMINAL JUSTICE COMPLEX
JACKSON, TENNESSEE 38301
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APPEARANCES

Before the Honorable:

JUDGE ROY B. MORGAN, JR.

For the Petitioner:

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-and-

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THE COURT: All right. We're ready to continue with the hearing in the matter of Jon Hall versus State of Tennessee.

At the time of the last hearing, on or about September 4th, the Petitioner had rested, and the State had asked for a continuance to have the opportunity for examination review.

General Earls, I guess we start with you.

MR. EARLS: Yes, sir. The State would call Dr. Kimberly Stalford.

THE COURT: Is there any reason, as she's coming forward, to call for the rule? Should anybody need to be excluded at this point?

MR. BUCHANAN: Because myself and Ms. Higuera were present when she interviewed him, let's ask Ms. Higuera to step outside in case there's some kind of conflict that pops up.

THE COURT: Okay. I appreciate your caution on that.

General, anything for the State as far as exclusion?

MR. EARLS: No, sir.

THE COURT: Call that witness then.

DR. KIMBERLY STALFORD was called and being first duly sworn, was examined and testified as follows:

MR. ELLIS: Your Honor, before we begin, Mr. Hall has indicated he wants to look at the report before she begins testifying. He just recently got it. Can we take about three minutes? We have a copy over here.

THE COURT: He's not had an opportunity to see it?

MR. ELLIS: No, Your Honor.

THE COURT: Sure. You're welcome to take a moment and share that.

THE PETITIONER: I didn't get to see Dr. Caruso's report before he turned it in.

MR. ELLIS: Your Honor, to save time, on the -- when we were here on the

4th, we had assumed that we had put into evidence the closing arguments, opening arguments and the mitigation arguments from the original trial date. I talked to the court reporter. She said that she had checked her notes, checked the record, and she didn't see where they were formerly introduced. However, they were marked. As you will recall, Your Honor, you agreed in the summer, and I believe it was the May hearing, to allow those to be typed up to enter into the record. We just want to put them in, I guess under the prior hearing date as Exhibit 14 just for simplicity sake, or we can enter them today, however you want to do it.

MR. EARLS: I have no objection to them coming in, whatever is convenient for the Court.

THE COURT: Would it be a collective exhibit?

MR. ELLIS: They are, Your Honor.

THE COURT: And again, it's opening argument, closing argument and --

MR. ELLIS: May I approach the court reporter, Your Honor?

THE COURT: Make sure we've got it properly marked.

MR. ELLIS: Your Honor, for the record, these are the closing arguments of February 4th, 1997, the opening statements and closing arguments, penalty phase, February 5th, 1997, the State's opening statement, February 3rd, 1997.

THE COURT: Let those be made the next exhibit.

(Collective Exhibit 14 was marked and entered.)

MR. EARLS: Your Honor, also by agreement, the State has a document that's the order transferring venue to Madison County. I don't think there's any objection to that.

MR. ELLIS: There's no

objection, Your Honor.

THE COURT: That's a copy of the previous order. Is that correct?

MR. EARLS: Yes, sir.

THE COURT: It was referred to at the last hearing as part of the record?

MR. EARLS: Yes, sir.

THE COURT: Okay. By agreement, it will be marked an exhibit also.

(Exhibit 22 was marked and entered.)

MR. ELLIS: We're going to let the General start questioning her about her credentials and work through the C.V. just to save time.

THE COURT: Go ahead. Start and state her name and proceed, General.

DIRECT EXAMINATION

BY MR. EARLS:

Q Would you state your name for the record, please?

A Kimberly Stalford.

Q And are you licensed to practice

a profession here in the State of Tennessee?

A Yes, I'm licensed to practice medicine in the States of Tennessee and Kentucky.

Q In conjunction to that, do you have any specialties in the field of mental sciences or anything of that nature?

A Yes. I'm a board certified adult psychiatrist.

Q And, Dr. Stalford, if you will, tell us a little bit about your employment history.

A After completing my psychiatric residence in Baltimore, Maryland, I stayed on there and worked at a mental health outpatient clinic and stayed there for two years.

We then moved to Tennessee where I was in private practice for a short time. I now serve as a consultant, and I work as a consulting liaison psychiatrist to Gateway Hospital,

Tennessee Christian Medical Center in Nashville and Cumberland Hall in Kentucky.

Q Okay. Tell us a little bit about your education if you would.

A I studied microbiology and biochemistry at Wesleyan University in Middleton, Connecticut. I entered the University of Virginia Medical School and completed their four-year program, and then I entered a four-year psychiatric residency at Sheppard and Enoch Pratt Hospital which is a large psychiatric hospital outside of Baltimore, Maryland.

Q And, have you passed any boards or anything of that nature?

A Yes, I am fully board certified. I passed my boards, Part I, which is a written test, and if you pass that, you go on to your oral boards, and I passed that as well.

Q Now, you are board certified in psychiatry. Is that correct?

A That's correct.
Q Anything else?
A No.
Q Now, tell us about honors or awards you may have received in your academic career or your work -- pursuant to your work.
A In college I was Phi Beta Kappa, which is an academic award, and in medical school I graduated with Alpha Omega Alpha honors, and in residency I had -- I can't remember specifically what they were but teaching awards and advisor resident of the year award.
Q And do you have any research experience?
A I have some research experience, mostly with aggression in rats and lesions, and I did some work with the Navy with the dengue virus.
Q And do you belong to any professional societies?
A Yes. I'm a member of the American Psychiatric Association and the

Tennessee Psychiatric Association.

Q Okay. And, pursuant to your present employment -- Well let me ask you this. In the past, have you been called upon from time to time to evaluate or consult with people who are charged with crimes?

A Yes, I have.

Q And on how many occasions have you done that?

A Probably about six.

Q Six. And, have you been qualified as an expert before in court?

A Yes, I have.

Q Where is that?

A In the State of Maryland, State of Tennessee and the State of West Virginia.

MR. EARLS: Your Honor, I'd tender the witness as an expert in the field of psychiatry.

MR. BUCHANAN: We agree to that, Your Honor.

Q Dr. Stalford, in September and

October of this year, were you contacted by my office to conduct an evaluation on Jon Hall?

A Yes.

Q And did you conduct such an evaluation?

A Yes, I did.

Q Tell the Court what resources or source information you -- was supplied to you or that you obtained in doing your evaluation of Jon Hall, please.

A I reviewed the Transcript of Evidence, Number 96-589, dated 2/4/97. I interviewed the Defendant on October 23, 2002 for three and a half hours in the presence of his attorney and April Higuera. I reviewed the psychiatric evaluation of Jon Hall by Keith Caruso; the forensic neurological evaluation of Jon Hall by Pamela Auble. I read the indictment for first degree murder, theft of property and especially aggravated kidnapping. I read multiple interviews by the TBI, a report of his

criminal history, a report of his disciplinary action; various letters written by Jon Hall to someone who is just Brent, Judge and Valerie. I reviewed two --

THE PETITIONER: That's illegal information. That stuff should have been --

THE COURT: Mr. Hall, talk to your counsel rather than blurt out in the middle of the testimony.

THE PETITIONER: Well, I've been telling them and they haven't been saying anything.

THE COURT: Go ahead, General.

THE PETITIONER: State v. Bank, --

THE COURT: Mr. Hall, ...

Q Talking about reviewing certain letters to the TBI -- or from the TBI?

A Letters written by Jon Hall to Brent, Judge and Valerie. And I did review interviews of the TBI of Cindy Connor, Jeffrey Hall, Jackie Brittain

and Michelle Johnson, Carol Eason, Darlene Brown. I reviewed two Petitions for Orders of Protection, one filled out by Billie Hall on 3/10/94, the second on 7/5/94. I read a civil summons regarding the divorce. I reviewed a bill from Baptist Memorial Hospital; a police report of domestic disturbance from 5/31/91. Mr. Hall gave me a document entitled "Specific Instances of Acts or Omissions of Counsel"; procedural history of State of Tennessee versus Jon Hall. I reviewed the autopsy report of Billie Hall and was able to get the medical records from Middle Tennessee Mental Health Institute and reviewed all of those.

Q And, did you go over his social history?

A I did.

Q And from that, could you just summarize what you learned about his social history, please?

A Anything in particular?

Q Well, let me go on. You did look at his social -- Jon Hall's social history. Is that correct?
A Yes, I did.
Q In looking at his social history, what do you normally look at?
A We get a biographical description on where a person's born, their childhood, their educational experience, their work history, their interpersonal relationships throughout their life, drug and alcohol use, issues such as that.
Q And, did you look at his medical history?
A Yes, I did.
Q Was there anything significant about his medical history?
A No, nothing very significant. He does complain of kind of chronic back pain for which he's not receiving any treatment right now.
Q To your knowledge, is he on any medications?

A No, he told me he was not taking any medications.
Q And did you talk about his work history?
A Yes, I did.
Q And family history?
A Yes.
Q And did you consider his past psychiatric history?
A Yes.
Q Okay. And how did you obtain that?
A By reviewing the records I just discussed and also by interviewing Mr. Hall.
Q Now some of those records were records obtained from Middle Tennessee Mental Health. Is that correct?
A That's correct.
Q And did you also look at any past legal problems he had?
A Yes, I have.
Q And did you denote those incidents in a report that you prepared

for our office?
A I did.
Q Dr. Stalford, expressly, were you asked by my office to consider a disorder designated in the Diagnostic & Statistical Manual of Mental Disorders, Volume IV, known as intermittent explosive disorder?
A Yes.
Q And did you consider Jon Hall in interviewing him and looking at his past records with regards to that disorder?
A That disorder and any other psychiatric disorder.
Q Okay. Now, what is the Diagnostic & Statistical Manual of Mental Disorders?
A It is a book which is a guideline for medical professionals in diagnosing psychiatric illnesses, and it's divided in groups of mood disorders, psychotic disorders, impulse control disorders, personality disorders, and it has a criteria for

which to make those diagnoses.
Q Is that a resource that is commonly used by people in the psychiatric or psychology -- or field of psychology in making diagnoses?
A Yes.
Q Tell us what intermittent explosive disorder is, or what the diagnostic criteria are according to the DSM-IV.
A Intermittent explosive disorder is a psychiatric disorder that falls under the impulse control disorders like cleptomania, and it is classified by impulsive outbursts which usually inflict harm on objects or people. The diagnosis is -- describes -- The second criteria includes the outbursts in excess of what one would expect, and the third aspect of that diagnosis is that it can't be better explained by another psychiatric illness.
Q Now, in your evaluation of Jon Hall, what conclusion did you reach with

regards to intermittent explosive disorder as to whether or not Mr. Hall had that disorder?

A I do not think he has that disorder because I think that his behaviors are better described by other psychiatric illnesses.

Q And that is one of the diagnostic criteria of the DSM-IV. Is that correct?

A Yes, that the aggravated assault acts are not better explained by another psychiatric illness.

Q What psychiatric illnesses are you talking about that, in your opinion, better explain Mr. Hall's conduct?

A I believe that he has what we would describe as a personality disorder, and very much as Middle Tennessee described it, where he has some passive/aggressive traits, dependent traits, but I think the most notable traits are what we call anti-social traits or sociopathy, and within

that diagnosis, there is a reckless disregard of other people and agitated and potentially violent acts, and I think his behavior is better explained under that diagnosis than intermittent explosive disorder.

Q And, reviewing the record in this case and all the documents you've referred to, did you also consider the use of alcohol?

A Yes, I did.

Q And what affect, in your opinion, did the role of alcohol play in Mr. Hall on the date alleged where he killed -- or alleged -- or did kill Billie Jean Hall?

A Well I also gave him a diagnosis of alcohol dependence. Mr. Hall has a very long history of abusing alcohol and had told me that he had been drinking daily for at least a year prior to that. So, certainly the alcohol can affect one's behavior.

He could not really report how

much he drank that night. I do believe he was very tolerant to alcohol. If you drink 12 beers every day for a year, you become very tolerant to the effects of it. So I did diagnose him with alcohol dependence as well.

Q Now, Doctor, what is serotonin?

A Serotonin is a chemical in our brains. It is the way that nerves connect. When you have a nerve and the nerve stops, you need that nerve to talk to the next nerve, and the way it does it is the nerve releases a chemical that causes what we call the synapse to the next nerve, and that's how the nerves talk. And one of the chemicals in the brain that does that is serotonin. There's Dopamine or epinephrine, GABA, but serotonin is what we call a neurotransmitter which basically is the way that nerves talk to each other.

Q Doctor, with regards to being able to diagnose Mr. Hall, or any other person for that matter, using serotonin,

tell the Court what some of the inherent problems of using serotonin to make a diagnosis are.

Q Well we don't actually do a blood test. There is some research that has been an area of active research for several years now that they study the serotonin levels in the spinal fluid or in the CSF, and we can do a lumbar puncture and measure the serotonin in the CSF. The inherent problem is that when you measure the serotonin in that area, you're not necessarily measuring how much serotonin is actually between the nerves, you're measuring serotonin in a fluid that bathes the spinal cord and the brain. So that's probably one inherent problem.

The other inherent problem is you're only getting a serotonin level at that exact moment. It doesn't necessarily say what was true a week ago, a day ago or a month ago.

And the third inherent problem

with that test is that there's so many medical, neurological and psychiatric conditions that have been linked to altered serotoninergic levels that it's really not a terribly useful diagnostic test, which is why the forensic unit at Middle Tennessee doesn't even do it.

Q Could you tell us some of the physical or psychological problems that are associated with low serotonin levels?

A Some of the things psychiatrically associated with low serotonin classically has been depression. We treat depressed patients with what's called SSRI's or selective serotonin reuptake inhibitors, and these drugs increase serotonin in the brain. They've connected low serotonin levels to folks that suicide. They've connected low serotonin levels to patients with schizophrenia. And, in fact, one of the classic anti-psychotics we use is Clozaril which increases

serotonin in the brain. Bipolar disorder or manic depressives have been known to have low serotonergic levels. We've seen it with impulsive acts of violence. We've seen it with mood disorders. We've seen it with personality disorders. It's been seen with anti-social personality disorders, and there is some research that we've seen it with borderline personality disorder. Neurologically it's been connected to myoclonus, dementia, sleep disorders, and medically it's been connected to malnutrition.

Q And I didn't keep count with the number that you went over there, but -- that you testified to, but to do a serotonin test and their -- based upon whatever the results are to say he, therefore, has this disease, would that be a valid conclusion?

A No.

Q Because it could be one of dozens --

A It could be any one of those things.
Q Did you review the serotonin tests that were done on Jon Hall?
A I reviewed the results that were described in Dr. Caruso's report. I never actually saw the lab of that test.
Q Okay. And, Doctor, did you, pursuant to our request, consider diminished capacity, or the area of diminished capacity, in your evaluation of Jon Hall?
A Yes.
Q And tell the Court about your conclusion, please.
A It is my opinion that based on several instances and aspects that happened that night, that Mr. Jon Hall was able to think clearly and was able to plan certain aspects of that night and was not -- was not grossly affected by drugs or alcohol or any psychiatric condition that would explain a loss of control.

Q Now, Doctor, just one last question. The diagnostic criteria you went over in the DSM-IV, you said there were three I believe, is that correct, for intermittent explosive disorder?
A That's correct.
Q Was one of those low serotonin?
A No. No.
MR. EARLS: Pass the witness.
THE COURT: Mr. Buchanan.

CROSS-EXAMINATION

BY MR. BUCHANAN:

Q Doctor, when did they start writing the DSM-IV? Do you know?
A I actually don't know exactly when. It's been several revisions, and this is the IV. I don't know when the very first one was written.
Q If you were to find out that the DSM-IV -- they started writing it in 1988, do you know of anything that would contradict that?
A No, I wouldn't.
Q And do you know the publish date

of it?
A No, I don't.
Q Would you look in the front of it and see if we can agree that it's 1994?
A I'm missing the top, so hopefully it won't be -- Yes, 1994. Second printing, July 1994.
Q Okay. And you would assume there would be some input on it some years before that, before they came up with the final draft; would you not?
A Right. It's a constantly changing manual.
Q In fact, there is under consideration a DSM-V as we speak; is there not?
A I'm sure there is.
Q Okay. Are you familiar -- I just want to ask you a few things about your background. Are you a member of either the Attorney General's Conference or the Defense Lawyer's Conference?
A No, I'm not.

Q Okay. Have you ever made any presentations at either one of the -- either the Defense Lawyer's seminars or the Attorney General's seminars?
A No, I haven't.
Q How many times have you testified in court? Feel free to give me an approximation. I'm not ...
A I'd say between eight and ten.
Q Between eight and ten? How many times for the defense?
A Probably four.
Q So your testimony then pretty much is even-handed in terms of testifying for defense, testifying for the State.
A Usually I interview the patient and write my report, and I don't really necessarily work for one side or the other. I am evaluating a patient.
Q Did you see in -- The social history that you had to go on was primarily social history that was contained in Dr. Caruso's report. Is

that fair to say?
A No, because I also drew records from Middle Tennessee as well as from interviewing Jon Hall.
Q Okay. Middle Tennessee didn't have one reference to anybody interviewing any sibling, did it?
A No. I believe they interviewed his mother, Mr. Helms, Billie Hall's mother, and I believe there was one other person I'm blanking on.
Q No siblings. Do you know how many siblings he has?
A I believe he has seven.
Q Would you agree with me that all of the psychotic disorders that are spelled out by the DSM, by and large these are conditions that normal-looking people walk around with every day? It's not like there's a wart on their nose or anything else that sticks out that you'd see walking down the street. Is that fair to say?
A For psychotic disorders?

Q Yes.
A No, that's not fair to say. There is such a huge range with the psychotic disorders from folks that are medicated and doing wonderful and you would never to know to folks who are at the corner screaming and talking to themselves and you immediately would know.
Q All right.
A There's a great variance.
Q But for instance, intermittent explosive disorder and impulse control disorder and anti-social disorder, you -- that's something that you're going to have to diagnose after a professional gets a history and interviews the person and things of that nature. You're not going to see those by and large when you're just walking down the street for those types of things, are you?
A Those would be non-psychotic disorders. The anti-social personality disorder, intermittent explosive

disorder and impulse controls are not psychotic disorders. And, yes, traditionally if you walk down the street and you saw someone who had cleptomania or was a sociopath, you wouldn't be able to make that diagnosis by looking at them.

Q That's the same exact way we actually diagnose Alzheimer's, isn't it, through interviews and social history and medical history?

A Yes.

Q Now we can tell someone had Alzheimer's after they died. We can actually look at the brain and see the evidence of it, but we don't have a clinical test for it, at least as of now, do we?

A No, we don't. We do do CT's and MRI's of the head, and we can see cortical atrophy, and we can get a good history, but you can't make that final diagnosis until after death.

Q And would you agree with me that

the psychiatry and the psychology field is grasping, even as we speak, for those types of tests that are biological markers that help diagnose these sorts of things?

A Yes. Psychiatry is a non-science.

Q Okay. Are you familiar with the writings of Emil Coccaro?

A I am not.

Q All right. Did you review Dr. Caruso's testimony before you did your report?

A Yes, I did.

Q After you read -- Do you remember what he said about Emil Coccaro?

A I don't.

Q Well, if he said on Page 93 that he had done significant research into this serotonin level being a biological marker for intermittent explosive disorder, did you find anything to contradict Emil Coccaro specifically on

his research, or anybody that -- any article that said Emil Coccaro is wrong?

A Well, no, I do think -- and the DSM-IV actually says -- it says it quite clearly in there, in our manual, that in some individuals, -- and I can read it to you.

"In some individuals with intermittent explosive disorder, they have found low serotonin levels."

In some, not all, and they do not know what the meaning of that is. So there are people who have intermittent explosive disorder who do not have low serotonin levels, and there are some that may. The challenging thing is that there are so many other things that can cause low serotonin levels, and the bulk of the research is really with depression and suicidal -- on patients who have committed suicide. So, there are patients who have intermittent explosive disorder who have low CSF, serotonin levels, but it's

some, and it's not an exclusive aspect.
Q Do you remember what Dr. Caruso -- And, now, we have established, have we not, that we agree that you did not see the actual serotonin report itself?
A No, I did not see the actual report itself.
Q Do you remember when you read Dr. Caruso's testimony where Jon fell in the general population for serotonin level on a percentile basis?
A I believe it was five percent.
Q As low as five percent of the population. Correct?
A Yes.
Q Can we agree that that is an extremely low serotonin level?
A I'm not sure that there's very clear evidence as to what normal is. I believe there's very -- For instance, like a white blood count. We have ranges of white blood counts that the lab gives us as normal, from five to ten, but many people live at four, and

some people live at eleven. So if you have a white count of four or five, I'm not really sure that means that much.

Q Well at least we can agree, can we not, that there's 95 percent of the population that has higher serotonin levels that Jon Hall?

A If that report says that. I'm not necessarily sure that I think that's -- believe that report, but I think this is an area of such tremendous research -- And one of the problems is that when they do do these CSF levels, they're drawing them on patients who may have psychiatric illnesses and medical illnesses. Most of us who have relatively good health aren't having our CSF level checked for serotonin. So I think it's just a very challenging area right now.

Q Do you have any article or documentation that disputes what Emil Coccaro came up with in his published findings?

A No, I do not. I do have articles, though, on some of the other medical and psychiatric conditions that can cause low serotonin.

Q You said that you believe he does not have intermittent explosive disorder. Would you allow any chance that he may have it?

A No, I don't think he has it.

Q Well I understand you don't think he has it, but are you saying that Dr. Caruso's absolutely wrong, or would you at least allow that he perhaps might be right?

A I think he's wrong.

Q You think he's wrong?

A I do.

Q I don't mean to argue with you, but we're back to that think thing again. Are you prepared to testify that he is wrong, or do you allow chance that he might be right?

A Psychiatry -- I think you could have 20 psychiatrists and all 20 could

testify on 20 different things. It is so not an exact science. But, --

Q I'm so glad you said that. That's going to take care of about 20 questions I had at some point.

A But I believe he's wrong, and I would testify to that, because Mr. Hall's personality structure -- And this has been supported through the MMPI. I believe that his violence and his disregard of life of others and his disregard of the rights of others is related to a personality disorder, not to an intermittent explosive disorder.

Q Did you ever read anything in his social history, in the social history that you were provided, about what a kind person he was and the kind things that he did throughout his life?

A I don't recall reading very much about that.

Q Okay. And would you agree with me that a social history -- For instance, it would be almost foolish for

any professional, either a psychologist or a psychiatrist, to just interview a patient and not get some kind of history about what really is going on in his life?

A And certainly when I met with Jon Hall and also spoke with you, Jon Hall talked about some of the positive things that he has done. We talked about taking care of the children when his wife worked, and my assessment -- certainly I reviewed the records, but I also spoke with him for three and a half hours, and I got a pretty good history of some of the kind things he has done in the past.

Q Well I understand that, but whether it's good or bad, just relying on the defendant is not a good procedure, is it? I mean, you do, in fact, want to get social histories that talk to family members and --

A That's right.

Q -- co-workers and things of that

nature.
A That's right. And as I told you, and I think this -- I would read whatever was handed to me.
Q But you as a professional, if you're not handed it, then that obviously doesn't go into your diagnosis. Correct?
A It doesn't go into the diagnosis, but hopefully it would go into the diagnosis by your interview of the patient.
Q Would you normally expect an attorney that would hire you to interview his client, -- would you expect him to provide you with some background material and social history on the individual?
A I'm not sure I understand your question.
Q If I called you up today and hired you as my expert to give me your best diagnosis of Defendant X, would you expect me to provide you with some

background or some social history, some something about him as opposed to just interviewing him?

A Yes. I would want everything you had.

Q Okay. And you would hope that I had done a thorough -- as thorough as possible job; would you not?

A Yes.

Q Because your diagnosis is directly related, in many regards, to the quality of the background information you have. Is that correct?

A No. The diagnosis ultimately is going to be based on I think that clinician doing an interview. The background information is very useful, but you also have to take everything you get with a certain grain of salt because you may be hearing things -- I've heard so many contradictory things, and if you read, that's very different from what someone reports. So, you take it all in and you put weight on it, but ultimately

it's your meeting with that person that will help you make that decision.

Q Okay. But if you're not given anything about the good side of a person, or if bad things are left out, that, to some extent, hurts you in your attempt to come up with a diagnosis; does it not?

A The more information that a clinician has, the better they will be able to come up with a most accurate diagnosis.

Q Okay. You said in your report on Page 11 that he had a history of deceitfulness. Can you tell me the deceitfulness things that you saw and the background that you saw that caused you to say that he had instances of deceitfulness?

A Well just directed with me, he reported to me that he struck his wife five or six times, which I think is -- when you look at the coroner's report, is in polar opposite of what I believe

must have happened there. Also, he had reported to the staff at Middle Tennessee that he put his wife's body in the water to revive her, and when I asked him when he left the scene, did he remove her or did he take her out of the water, and he said no. Things like that don't make sense.

Q And you characterized it as not making sense but as him being deceitful?

A Yes. I don't think he was being honest with me.

Q Did he not tell you that he only remembered hitting her five or six times?

A I don't recall whether he -- I said, "How many times did you hit her," and I recall him saying, "Five or six times."

Q Okay. And you think that's -- Did you go any further than that in trying to cross-examine him?

A Yes. I asked him about the coroner's report and that there were 83

separate blows and contusions, and I believe his response was that the coroner was -- I can't remember how he phrased it but --

THE PETITIONER: Was a quack.

A Was a quack.

Q Okay. And you took this to be deceitful.

A Yes.

Q Okay. Is there anything in the social history, other than what you've testified to, as -- that gives you the conclusion that he's deceitful?

A I think he's done behaviors in the past that demonstrate distrust -- I mean, untruthfulness. I think disconnecting phone wires and -- I have questions as to his truthfulness with previous restraining orders and what truthfully happened in those restraining orders.

Q Well this is what I want to take up with you. You saw in the histories that you looked at, even some State's

material, that there were instances in the past that this man had disconnected phone wires at residences in which nobody was killed. Correct?

A Yes, that's correct.

Q Nobody was beaten severely.

A Sometimes people were severely injured. The one instance, I believe he, while rolling a marijuana joint, lit the couch on fire with one of the children in the house. So sometimes when he cut the phone lines, people were injured, and sometimes -- not cut but disconnected, and sometimes when the phone wires were disconnected, there was a fight, and I assume nobody was harmed.

Q Well, I'll concede with you he killed a couch, but I'm asking about violence toward people. You didn't see any disconnecting the phone lines and then hurting any person in particular, did you?

A I don't know if he disconnected the phone wire on the incident in July

where Billie Hall may or may not have been hit with a bottle and went to the hospital with supposed injuries. I don't know if the phone line was disconnected that day.

Q Yeah, but what I'm asking you is, can you remember any instances in which the phone lines were disconnected that it was followed up with some sort of a grand plan to hurt the person?

A I can't answer that because I don't know if he disconnected the phone wires in July of '94.

Q Okay. Ma'am, I take from that that you have instances wherein he did, in fact, disconnect the phone wires and no one was hurt.

A Yes, that's true.

Q Okay. You say this CSF serotonin level is an area of active research and in no means is a diagnostic tool for any psychiatric condition. Is that what you believe?

A Yes.

Q But you have not -- you also said you had not read or were familiar with Dr. Emil Coccaro's research. Is that --

A No, there's many researchers, and I have many reports here, but that is one I may have read but the name is not ringing a bell for me.

Q Okay. That is -- Taking serotonin levels and trying to make it a biological marker so that, say, when the DSM-V comes out -- The DSM's are put together by a panel of psychiatrists; are they not?

A I believe that's true.

Q And to where that would be accepted, you have to do research so that if a DSM-V or -VI or -VII is ever written, you can go to that panel and say, "I have the research which I would like included as a diagnostic tool," and then that panel has to decide whether or not your research was valid or not before they put it in.

A That research is already done and included in the DSM-IV with low serotonin levels and various psychiatric illnesses.
Q Well you're not saying that since 1988 or 1994 that we haven't made a little progress, are you?
A Oh, we have made progress. Absolutely.
Q Okay. I mean, there's research going on as we're standing here today. Isn't that correct?
A Yes.
Q And you would expect, would you not, that five years from now we'll know more than we know today?
A Absolutely.
Q "NOS", just for the record, that's not otherwise specified? Is that --
A "NOS" is not otherwise specified.
Q You also said in your report that you believe he was fully capable of

premeditation.
A Yes.
Q It was also possible that he was capable of a very impulsive act. Is that correct?
A I don't believe that his actions that night and some of the evidence is based upon --
Q Excuse me. Let me remind you of my question. Capable. He was capable of an impulsive act; was he not?
A Yes.
Q Just as capable as he was of premeditation.
A Yes.
Q And we have to look to, do we not, and you have to look to, the surrounding facts and figures before you come up with idea of whether you think it was premeditation or you think it was an impulse control problem or whatnot?
A That's correct.
Q Okay. You say he has no mental disorder that prevents him from

premeditation, but impulse control -- you're not diagnosing him with impulse control disorder, are you?

A No, I'm diagnosing him with two drug use problems, alcohol and marijuana, and a personality disorder that includes passive/aggressive, dependent and sociopathic traits.

Q Okay. Going back to the DSM-IV, the 1994 DSM-IV, you have said there were diagnostic criteria, number one of which is outbursts in excess of what one would normally expect.

A Well the first one is failure to resist aggressive outbursts. The second criteria is that those outbursts are in excess of what one would expect, and the third one is that it's not better explained by another disorder.

Q Am I understanding you that you basically don't have that much of a disagreement that Jon might have number one and number two, but where you really think he falls off of that diagnosis is

with number three? Is that correct?
A I do think he has demonstrated in the past to be impulsive, and that's been shown on his personality testing. I don't believe two -- I don't know that -- I don't know that his response was in excess of what -- You know, that's like a small thing, something small happens and then, boom, you know, the person explodes, and I don't think that happened.
Q Where you really find disagreement, though, is with number three. Is that fair to say? That you think it's better explained by other things?
A Yes, I do think that what impulsive behaviors he does have are better explained by other psychiatric disorders.
Q Okay. Serotonin levels vary somewhat, but they don't rise from the lower five percent to the highest five percent over a lifetime, do they?

A I can't answer that because they've done no research, and again, most of the studies that they've ever done are on medically ill, neurologically ill, psychiatrically ill. So I don't think we have a really good lifespan study or normal study or anything of that nature.

Q So when Dr. Caruso -- if he were to have said that the serotonin levels don't vary a lot over a lifetime, you'd disagree with that.

A I would because we know that those serotonin levels can drop in some patients with depression. So if you test the person when they're depressed, you could expect a low serotonin level. If you test them when they're not depressed, that serotonin level could be normal. I think it's such an area of research, we don't know. The truth is, we just don't know, and as much as I would love to have a lab test and make a psychiatric diagnosis, we are so far

from that.
Q At least -- Do you think if you read the research of Dr. Coccaro that that could affect your opinion on that?
A No, I don't because the -- there are so many things that research has shown to cause a low serotonin level.
Q So I guess it is fair to say that there's not much that's going to change your mind on that.
A No.
Q Okay. If I'm understanding you correctly, you're saying that one of your problems with the serotonin research is that they're pulling it from people who are a population that are full of problems to begin with. Is that a shorthand of what you're saying?
A Well the bulk of the research is with neurological issues, sleep disorders and some psychiatric issues.
Q So you're saying that these people have these sorts of issues, and they're primarily the ones they're

pulling the serotonin from?
A Many of the studies, yes.
Q But again, you're not familiar with Dr. Coccaro.
A No. I am familiar with the studies connecting intermittent explosive disorder with low serotonin levels. Now who actually the name behind that research is, I'm not familiar.
Q Do you know that he made a presentation at the American Psychiatric Association convention just in the last two years?
A No, I did not know that.
Q That's basically how a person that has left medical school and left their residency -- seminars are basically how you as a professional keep up with the latest -- that and your own reading, keep up with the latest things that are going on in your profession. Is that fair to say?
A No. I receive weekly journals,

American Psychiatric Journals, the newsletters, the magazines, the -- we get monthly a big journal, and you would have to read that information monthly to keep up. The conference is once a year in various parts of the country, and there are hundreds and hundreds of seminars going on. You may be lucky if you can go to a handful. So really, a psychiatrist will keep up with the current information by reading their weekly journals.

Q Okay. I thought my question said that and reading. But that is the way you catch up and stay up, is you go occasionally to a seminar and you do your reading of whatever journals you subscribe to. Is that --

A That's right.

Q Okay. Would it surprise you for a certain defendant to give you a history and then you talk to immediate family members and siblings and things of that nature and find that what he has

told you, or she has told you, is in many ways contradictory to what you're hearing from so many other people in the family?

A Frequently when I get a social history there is differences in how people recall things.

Q And again, that's why, as you said, you'd read anything that's given you on the theory that the more you read, the more you're helped. Is that fair to say?

A That's fair to say.

Q You would not expect an attorney to hire you and not provide you anything, would you?

A No, I would not.

Q And, just for the record, you conducted no family interviews yourself with any of the siblings.

A No, I did not.

Q Your family history, as I read your report, takes up about two inches on Page 4; does it not?

A Right.
Q Do you think if you'd have interviewed Sheryl -- By the way, did you read Sheryl Arbogast's testimony from this proceeding?
A I do not believe I did. I think we talked about that and you were going to send me the hospital -- that and the records from Middle Tennessee, and I did not receive those.
Q I had offered to send you a digest of the original trial, but what I'm referring to is Sheryl Arbogast's testimony in this proceeding, which I don't think -- I've never digested.
A I don't believe I read that.
Q I'm just asking you, did you read it?
A No, I do not believe I have.
Q Okay. Do you think if you'd have read it and the other two sisters that testified, or if you had talked to them, that your family history might take up a little bit more than two

inches?
A I don't know.
Q Refresh my memory. I'm at the age where I worry every day about Alzheimer's in my own self because I don't remember things so well, but didn't I remember you telling me that you thought it was clear that he acted impulsively that night?
A No, what I said is, I think he's an impulsive young man, and I do think that he is someone who doesn't necessarily think through the actions. For instance, when he lit the couch on fire, I'm not really sure he thought that that house could burn down, and he did go back and help his wife put that fire out. We did discuss whether I thought that night whether that was an impulsive or a premeditated act, but I do think he has a tendency to be impulsive, yes.
Q But what you're telling me is that at least as regards the killing --

I'm calling it the killing of the couch, but we're talking about the fire that engulfed the couch, that didn't appear to be premeditated to you, did it?

A No, it did not. I think his wife said something to the effect that the house was in her name, and he thought he'd rather burn it down than have her have it, and so I do think that was -- appeared to me to be a relatively impulsive act.

Q You thought in that particular instance, that something the wife said set him off. Is that fair to say?

A I don't think he went to the house that day planning to light the couch on fire, no.

Q Nothing was premeditated as far as hurting the couch.

A Right, killing the couch.

MR. BUCHANAN: No further questions.

Well, just a minute, Your Honor. My learned co-counsel ...

Q The killing of the couch, would that be an example of an outburst beyond the norms of what society would consider appropriate?
A Yes, and I think that's a good example of his sociopathy.
Q But it also meets that second prong of the DSM on IED, does it not, that it's an outburst that you would normally expect?
A Not for a sociopath.
Q Not for what?
A Not for a sociopath. For somebody who has a disregard for the rights of others, who has a tendency towards aggressiveness and violence, a sociopath -- part of that diagnosis is violence and aggression.
Q Doctor, I don't remember you saying he was a sociopath anywhere.
A I said he has personality disorders with dependent, passive/aggressive, anti-social traits.
Q But, you don't diagnose him as a

sociopath.
A Yes, I do.
Q Where do you do that in your report?
A Well, personality disorder, I think he has the traits of anti-social personality disorder, but I think he also has significant dependent traits and passive/aggressive traits. So I think because it's a more complicated picture than just straight anti-social personality disorder, we give the diagnosis of personality disorder NOS.
Q Doesn't the American Psychiatric Association kind of frown on the use of the term sociopath?
A No.
Q In diagnosis?
A No.
Q Okay.
A I mean, in the research here, --
MR. BUCHANAN: No further questions.
A -- it's extensively used.

Q Ma'am?
A In research, it's extensively used.
Q Okay, that's fine.
Mr. Learned Young Co-Counsel has got some questions. I'm going to feed them to you if you don't mind.
A I don't mind.
Q You found out that -- You didn't think he was depressed in your report. Is that fair to say?
A When I saw him or at the time of the offense?
Q Both.
A At the time of the offense, yes, I do think he had some depressive symptoms. I think I wrote I don't think he met the criteria for major depression. It's hard to really say without having the chance to have interviewed him at the time, but I do think he had some symptoms of depression. I do think he had a lot of stress, but I don't think he met the

criteria for major depression. As indicated, he was working, and although albeit slower, was still going out to the bars with his friends. This is not someone that was in bed and having a difficult time.

Q Don't think he was depressed now?

A Now? He denied the classic symptoms of depression, although he did report that he had thoughts of suicide. So I don't think he met the criteria for major depression, but I do think this has been difficult for him.

Q Did you see any indication that he was a schizophrenic?

A No.

Q Now you'd said that the low serotonin levels were quite often associated with bouts of major depression and schizophrenia, but you didn't see those two things in him, did you?

A Not at the time I saw him, no.

Q So, at least, a low serotonin level is not inconsistent with IED, is it?
A No, low serotonin level is not -- we do see it in some patients with IED.
Q Do you think he was drunk the night of the offense?
A You know, I truly can't answer that. I don't know exactly how much he drank. I'm not sure he knows exactly how much he drank. He reported that he was, I think, trashed. I do know that -- I'm sure he had some tolerance to alcohol after drinking 12 beers every night, but I truly can't answer that.
Q Do you have a -- Did you get anything from the State in your materials that indicated that he was intoxicated that night?
A You mean a lab report or --
Q No, not even a lab report. Just anything from the State that indicated he was drunk that night or intoxicated.

A Yes. There have been reports that he reported that he had been drinking, and that one of the daughters said, "You're drunk." So I have read reports, and he said he was trashed, that he'd been drinking that night. We know he'd been drinking. I just don't know how much he had.

Q You saw a report from one of the children that said he was drunk.

A I read in one of the daughter's -- had testified that he -- and he told me that when he walked in the door, one of the girls said, "You're drunk."

Q Well, -- And I know this is difficult for you to do, but my question centers on things you were supplied by the State. Do you remember anything supplied by the State that indicated he was intoxicated?

A Sure, absolutely. Some stuff I got from Middle Tennessee, and what I got from the State was the Transcript of Evidence, February 4, and I don't know

that it said anything in there -- Oh, yes. There was the testimony of a doctor that said that he'd been drinking, and that led him to be impulsive. I read that. And I read Dr. Caruso's and Auble's report where he reported that he had been drinking. And in the State, I have letters that Jon Hall wrote where he reports that he was intoxicated.

Does that answer your question?

Q That's fine.

A I know he was drinking; I just don't know how intoxicated he was.

Q Just a point on the premeditation. You knew that he was a mechanic of sorts; did you not?

A Yes.

Q And there was a shed on the premises that had steel tools that you could use on a car for purposes of working on one.

A Yes.

Q Would you agree with me that if

you're going to premeditate a killing, that it would make awfully good sense with those type of blunt trauma objects available, to avail yourself of one to make the job a little easier?

A I don't --

Q I mean, that would certainly be an indication, would it not, that you'd planned it if you'd gone out in the shed and you picked up a blunt object, say a big old wrench, pipe wrench, and came in the house? That'd be a pretty good indication that at least by the time you got to the tool shed, you were premeditating some violence; would it not?

A Is your question -- Could you repeat your question? I got lost.

Q All right. If you were going to premeditatedly kill someone and you had available to you fairly easily tools that would help that situation along as opposed to your bare fists, if you, in fact, availed yourself of those tools,

that would be an indication of premeditation; would it not?
A Yes.
Q And, of course, if you didn't, then that's not an indication that you were premeditated in your actions. Would that be also fair to say?
A That you could premeditate a murder without getting a tool?
Q Yes. Now I understand you could, but if you didn't, then that would be one more thing that would tend to say, well maybe this was a more impulsive, spur-of-the-moment type thing. Is that fair to say?
A I don't think that's fair to say.
Q Okay. I've got one --
MR. BUCHANAN: I better check with my co-counsel, Your Honor.
Q Looking at the DSM on -- the one we're talking about that the episodes are not better accounted for by another mental disorder, and which one of those

-- I'll just go through them with you.
A Okay.
Q Anti-personality disorder, are you saying he's got that?
A What page are you on?
Q 612. Is there any supplement to the DSM yet?
A No, not that I know of. I do think he has anti-social personality disorder.
Q You think he has anti-social personality disorder?
A Yes.
Q Do you think he has borderline personality disorder?
A I know Dr. Caruso does. He's got so many personality traits, I tend to agree more with Middle Tennessee, that they're more -- he's more passive/aggressive and dependent.
Q Okay. Well, how about a psychotic disorder?
A He does not have a psychotic disorder.

Q A manic episode?
A He does not have a manic episode.
Q Conduct disorder?
A Conduct disorder is a diagnosis of a child, so -- I think he probably had that as a child, but you don't diagnose that in an adult.
Q You actually have very little history on him as a child. Isn't that fair to say?
A I had read -- I mean, I've read pages and pages of social history. I feel like I have quite a bit.
Q Do you feel like he has attention deficit hyperactivity disorder?
A No, I don't.
Q All right.
MR. BUCHANAN: Let me check one more thing, Your Honor.
A You know, the other thing, if you kept going, it says, "And are not due to direct physiologically --"

MR. ELLIS: Your Honor, I'm going to object.

A "-- effects of a substance, drug abuse."

Q Just a minute. Can you hold up 'til I get you a question?

A Okay, sorry.

Q Just a couple of things. You didn't see -- You said that he didn't remember a whole lot of seeing awful conduct between his father and his mother when he was young.

A What I recall him saying is he recalls three separate incidents, two involving his mom and one involving one of his brothers.

Q You wouldn't be at all surprised to hear that there were many instances of that, would you?

A I would not be surprised. And I think that's been shown in the record.

Q Now, do you remember the Middle Tennessee report, them talking about the brother in Texas that had the HIV?

A Yes, I did read about that.
Q And that report was dated sometime in 1994, wasn't it? 1994, 1995?
A When he was hospitalized?
Q Uh-huh.
A It was '95.
Q So there was some indication in the Middle Tennessee report that a lawyer or anything else that saw it could have found that he had a brother that was, in fact, dying of AIDS.
A That's correct.
MR. BUCHANAN: No further questions.
THE COURT: General, any questions?
MR. EARLS: Just briefly.

REDIRECT EXAMINATION

BY MR. EARLS:

Q You were asked several questions about a report, whether or not you had reviewed a report from another expert, and did I -- am I correct in saying that

there are dozens of reports out there, tests, or whatever, on serotonin?

A Yes. If you do a lit search on a med consult, there's voluminous amounts.

Q You really can't pick one and go with it, though, can you?

A No, you cannot pick one.

MR. EARLS: That's all I have.

RECROSS-EXAMINATION

BY MR. BUCHANAN:

Q I don't know if I finished it, but I know I started it, and I may have gotten off, but if I am, I apologize. But when we were talking about the statistical sample of people that have had serotonin drawn and you had concern as to the validity of all of those because you weren't convinced that the population at large had been taken enough that it could really statistically tell us much about psychiatric disorders, is that what I understood you to say?

A Well I have several big concerns. The first is that the serotonin level in the spinal fluid that bathes the brain and the spinal cord is not an indication of the serotonin activity in the synapses which is where it works. That's the first concern. The second concern is that there are so many illness that are affected by the serotonergic activity, and thirdly is that this is such an area of research right now that even the question of what are normal levels is very debatable.

Q And I think I'm honing in on that last thing you said. You're concerned that they haven't taken enough samples of enough people that they could really tell what's normal and what's not. Is that what I'm hearing you say?

A Yeah. Well we're still in the very early experimental stage, and I think that over time we will see more and more patterns of serotonergic activity, but I think it's important to

remember that you can have too floridly depressed people; one has a very low CSF serotonin level and the other will be very high. So the level -- You know, you may see a certain percentage of people with low serotonin level that are depressed or low serotonin level that has schizophrenia, but you can find just as many that have normal serotonergic levels and have psychiatric illnesses.

Q And that's depression and schizophrenia and not IED. Correct?

A Well IED, -- I mean, even in the DSM-IV they say -- and this is seen if you do med searches and you look it up, that, "Signs of altered serotonin and metabolism have been found in the spinal fluid of some impulsive and temper-prone individuals, but the specific relation of these findings to intermittent explosive disorder is unclear." So, yes, we've certainly seen it with explosive and violent people but not all.

Q So this was a test they were looking at fairly seriously in 1994. Is that fair to say?
A Well I think the world of psychiatry is aggressively trying -- they're studying Dopamine with intermittent explosive disorder, they're studying more epinephrine. I think they are desperately trying to learn more about the brain and how it works.
Q Is there a way to draw serotonin from the brain?
A Not that I know of, no.
Q Can a person have, in your opinion, low serotonin, let's say the bottom five percent of the population, and be normal? And I use that term meaning no psychiatric disorder.
A Yes.
MR. BUCHANAN: Thank you, Your Honor.
MR. EARLS: Just one quick question, Your Honor.

FURTHER REDIRECT EXAMINATION

BY MR. EARLS:

Q You were being asked about all these different disorders that Jon did not have, and you started to respond and say that there was something else and you were cut off. What was that?

A Well with intermittent explosive disorder -- And again, the important thing with intermittent explosive disorder is it's a failure -- it is a failure to resist aggressive impulses, not an inability to resist those aggressive impulses, but he was going over with me -- I forget what page it is now. Under "C", "The aggressive episodes are not better accounted for by another mental disorder and are not due to the direct physiological effects of a substance, drug abuse, including alcohol." So, what they mean when -- the psychiatrist that wrote this is that if someone's on cocaine and they have an aggressive outburst, you can't say it's

intermittent explosive disorder because you've got the cocaine complicating things, and Mr. Hall has such a long, long history of alcohol and marijuana abuse, that truly you cannot make this diagnosis.

MR. EARLS: Thank you.

MR. BUCHANAN: No further questions.

THE COURT: Is this witness free to leave the building?

MR. EARLS: Your Honor, I'd ask her to stay around, probably about ten minutes.

Your Honor, there's no objection from counsel for the Petitioner. The State is going to ask that a copy of the DSM-IV that we've talked about so much is going to be made an exhibit, talking about intermittent explosive disorder.

THE COURT: That's just that particular section of the DSM-IV that's being offered by agreement.

MR. EARLS: Yes, sir.

(Exhibit 23 was marked and entered.)

MR. EARLS: Also, there's no objection to Dr. Stalford's curriculum vitae and a copy of her report being made an exhibit, and I don't -- if the Court wants to make those collective, I have no objection, or you can do them separate.

MR. BUCHANAN: That's fine, Your Honor.

(Collective Exhibit 24 was marked and entered.)

MR. EARLS: State rests.

MR. BUCHANAN: Defense has no rebuttal, Your Honor.

MR. EARLS: Can I excuse Dr. Stalford?

THE COURT: Somebody can go out there and tell her.

Gentlemen, at this point, of course, this is a matter we've been involved with for well over a year with the proceedings regarding the PC

hearings. Do you agree that it would be better that I allow, first of all, the Petitioner's side time to submit final argument by brief form in making your argument and then let the State have time to respond but do the finality of it that way?

MR. BUCHANAN: That's fine, Your Honor.

MR. EARLS: Are you talking about a written brief, Your Honor?

THE COURT: Yes. And give you time because it has been, again, taking place over a large span of months here with everybody I know working hard on it. What I would like to suggest, I'd like to go ahead and get everything in our hands for final decision. If Petitioner's counsel could have something to me in two weeks' time?

MR. ELLIS: Your Honor, before we do that, we'd like to have the transcript first.

THE COURT: Oh, that's right.

I'd forgotten. I'd left Mrs. Mays out of the loop. We've got everything but today, hadn't we?

MR. BUCHANAN: But today.

MR. ELLIS: Your Honor, I still think that'd be very important.

THE COURT: Oh, I agree. I'd like to get this in your hands, both of you. I don't want the two-week period to start running until we know we can have that, so I'll just ask Mrs. Mays, depending on her schedule what she thinks.

Would you have it to them within a week or do we need longer?

COURT REPORTER: No, I can't do it this week. I can do it next week. I'll have it in two weeks, by the 18th.

THE COURT: You would have it to everybody by the 18th, and that includes a copy then for our side, too, for this.

And after that, I know you've got everything else and you can be working. You're down to just today's

hearing, so you can be working on it and taking it into consideration that both sides can be moving along. Let's still put two weeks from that date, December 2nd. Have yours in hand by December 2nd for Petitioner's side.

MR. BUCHANAN: That's fair.

THE COURT: And then could the State have it in my hands by December 16th?

MR. EARLS: Yes, sir.

THE COURT: So Mrs. Mays will have it to you by the 18th and then Petitioner's side by the 2nd of December and the State by the 16th of December in response.

Now, gentlemen, will that -- Go ahead.

MR. BUCHANAN: Judge, I just wanted to make sure, I'm anticipating submitting something that would be very similar to what I would tell you if I was here at this podium but with footnotes or references to the record

that you could check if you wanted to. Is that what the Court's looking for?

THE COURT: Yes, sir. I think that's what you want to do, and I'm agreeable to that.

And the State's agreeable to that?

MR. EARLS: Yes, sir.

THE COURT: And there was a missing page. There was Page 29 I believe of the amended petition. After some contact with Petitioner's counsel, there was a page finally submitted, but I'm understanding it was a renumbered 30. Number 30 was made 29, and it didn't add anything to what we thought was missing. So I just want you to know I can only rule on -- I don't know what's on the page, and I can only rule on what I've got.

MR. ELLIS: Well, Judge, I've got the whole petition. I'll just bring --

THE COURT: Well have you got it

with you?

MR. ELLIS: I've got it in my office. I'll get it to you this afternoon.

THE COURT: You know what you sent last time. It was a page that was renumbered from 30 to 29.

MR. ELLIS: I'll just -- Your Honor, I'll just -- to clear up any questions, I'll bring the whole petition this afternoon.

THE COURT: That's something we've been working on for quite some time, since about two months ago. So, this afternoon. No later. If there's something missing, I want to have it.

Anything further, gentlemen?

MR. BUCHANAN: No, sir.

THE COURT: Thank you, gentlemen. We'll stand in recess.

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END OF REQUESTED PROCEEDINGS.

COLLECTIVE EXHIBIT 14

Identified and authenticated, this the 18 day of July, 2003.

Roy B. Morgan

JUDGE

Kimberly F. Stalford, M.D.
1771 Madison Street
Clarksville, TN 37043
(931) 647-1453

PSYCHIATRIC EVALUATION

Name:	Jon Hall
Date of Birth:	August 5, 1964
SSN:	187-52-0101
Date of Report:	November 1, 2002

IDENTYIFYING INFORMATION

Mr. Jon Hall is a 38-year-old man who is currently incarcerated at Riverbend Maximum Security Prison. He was convicted of first degree murder of his wife, Billie Hall, who was beaten, strangled, and held under water on July 29, 1994 at her home in Madison County, Tennessee.

CONFIDENTIALITY

When I first went to meet with Mr. Hall on October 10, 2002 at 9:30 A.M., he refused to meet with me. His attorney had set up this time, but was not present. Mr. Hall stated that he would not meet with me without either his attorney present or videotape of the interview. My evaluation was rescheduled for October 23, 2202. I explained to Mr. Hall that I had been asked to see him by the Assistant District Attorney, Mr. Al Earls, and that I would be providing a report to his office and Mr. Hall's attorney if requested. I also explained that I might be asked to testify in court. He understood and accepted the non-confidential nature of the interview and agreed to proceed.

SOURCES OF INFORMATION

1. Transcript of Evidence No. 96-589, State of Tennessee vs. Jon Hall – 2/4/97
2. Interview of the defendant on October 23, 2002 for 3 1/2 hours
3. Psychiatric Evaluation of Jon Hall by Keith Caruso, MD on August 30, 2002
4. Forensic Neuropsychological Evaluation of Jon Hall by Pamela Auble, Ph.D. in August 2002.
5. Indictment for First Degree Murder, Theft of Property, and Especially Aggravated Kidnapping

6. Memorandum of Complaint submitted by Jon Hall
7. Interview of Cindy Connor by TBI
8. Report of Criminal History
9. Report of Disciplinary Action
10. Letter written by Jon Hall to "Brent"
11. Letter written by Jon Hall to "Judge."
12. Petition for Order of Protection filled out by Billie Hall on 3/10/94
13. Petition for Order of Protection filled out by Billie Hall on 7/5/94
14. Letter by Jon Hall to "Valerie"
15. Motion for the setting of child support
16. Interview of Valerie Lambert by TBI
17. Attempted interview of Jon Hall by TBI
18. Interview of Jeffrey Hall by TBI
19. Interview of Jackie Brittan by TBI
20. Interview of Michelle Johnson by TBI
21. Interview of Carol Eason by TBI
22. Interview of Darlene Brown by TBI
23. Civil Summons regarding Divorce
24. Bill from Baptist Memorial Hospital
25. Police report of Domestic Disturbance from 5/31/91
26. Document titled "specific instances of acts or omissions of counsel."
27. Procedural History of State of Tennessee Versus Jon Hall
28. Autopsy Report of Billie Hall
29. Medical Records from Middle Tennessee Mental Health Institute

SOCIAL HISTORY

The defendant was born in Pittsburgh and raised in Ligonier, Pennsylvania. He lived in Pennsylvania until the age of 20. He is the seventh child born to Jay Hall, Sr. and Carol Hall. His mother was 15 when she married her husband who was 19 at the time. At birth, the obstetrician removed the umbilical cord from the defendant's neck, but there were no permanent injuries or asphyxia. The defendant states that he would describe his childhood as "pretty normal." He denies any kind of physical or sexual abuse involving his parents, but states that he does have a lot of memories of aggressive wrestling matches with his brothers. He states that his brothers would "tickle me until I peed, give me knuggies, and sit on my chest." He recalls some of these interactions as feeling abusive. He recalls that he would"freak out" with aggressive temper tantrums in the hope that this kind of behavior would "get my brothers off of me." Although he states that

money was tight, he does not recall wanting of anything until he was in high school – and at that time, he wished for motorcycles, televisions, etc. He states that he did not feel deprived in any way. Mr. Hall graduated from highschool after attending high school for half of a day and auto mechanic school for the other half. He reports that he was a poor student and generally earned C's and D's in school. He began to demonstrate antisocial traits at an early age with drug and alcohol use starting at age 13 and brushes with the law. At age 13, he was charged with alluding police on a motorcycle, driving without a license, driving an unregistered motorcycle, and driving without a helmet. He later was charged with receiving stolen property when he knowingly bought a stolen stereo. He reports that he was placed in ARD. He has demonstrated problems with authority, irritability, theft, and frequent fights in his youth – again early indications of sociopathic behavior. He had difficulties in school as well stating that he "didn't listen" to his teachers and was suspended twice for drug possession. .

The defendant's father worked in construction. He was reportedly an alcoholic and Dr. Caruso's report states that he was physically abusive. However, Mr. Hall denied to me that his father was physically abusive to him. In fact, he can only recall three significant altercations involving his father – one where he damage a thunderbird, one where he "yanked the phone", and one involving his brother, Jeff. When the defendant was 10 years old, his father died of a heart attack. Mr. Hall reports that "I didn't know my father well." His mother remarried Mr. Ed Alexander shortly thereafter. There were allegations that Mr. Alexander was sexually abusing Sheryl and a divorce was pending when the defendant's stepfather died

The patient's mother worked as a bartender and waitress. She is still living and resides in the family home in Ligonier. The defendant reports that "she has been depressed all her life", but apparently has not sought psychiatric treatment. She does not drive, has COPD, and reportedly rarely leaves the home.

The defendant continued to have problems at home, at school, and with the law. He eventually moved to North Carolina in the early 1980's. The defendant met his wife in Fayetteville, North Carolina in August 1987 at their apartment complex. They began dating in November of the same year. Billie Hall became pregnant with Stephanie in March of 1988, and Billie and Jon were married on May 14, 1988. Billie Hall had two children from a previous marriage, Jennifer (born in 1985) and Cynthia (born in 1986) The Hall family moved to Tennessee in 1989 to be near Billie's family. Billie Hall began working as a telephone dispatcher at Jackson Memorial Hospital ambulance service in 1990. The defendant's youngest child is Jessicca and she was reportedly born prematurely and has had several medical problems. The patient reports staying home with the children from 1991 to 1993 while his wife worked as an ambulance dispatcher. The defendant demonstrated a previous history of aggressive and assaultive behavior towards his wife. In 1990, Mrs. Hall took her children and left the defendant. Mr. Hall became

enraged, chased her, and ultimately caused his wife's car to crash. Billie Hall fled to the house where Mr. Hall followed her after breaking down the door and disabling the phone. Billie Hall was able to call for assistance using a portable radio. When the police arrived, he climbed on top of the roof and began to pull shingles off. The couple separated and the defendant went to live with his mother in Ligonier, Pennsylvania. He began another relationship in PA. He returned to Tennessee over the 1990 Christmas Holidays and remained there. Billie Hall became pregnant in January 1991 with their second daughter who was born 15 weeks prematurely. She reportedly had an intraventricular hemorrhage and developed cerebral palsy and chronic respiratory problems. The defendant reportedly stayed home to care for the children from 1991 to 1993 while his wife worked as a dispatcher.

MEDICAL HISTORY

Mr. Hall denies any significant medical problems. He states that he may have degenerative disc disease and that his back felt briefly better after having a lumbar puncture,

MEDICATIONS

The defendant is not taking any medications at this time. He denies any known drug or food allergies.

WORK HISTORY

The defendant has had difficulty holding a steady job because of his problems with authority, his repeated tardiness, his feelings that he was being picked on, and his desire for greater pay. In his youth, he worked washing dishes, being a caddy, demolishing barns, and assisting a brick mason. The longest job he held was in Fayetteville North Carolina where he worked "off and on" for three years. He worked for one week with Columbus-McKinson Chain Factory, one year for Helms Motor Company, one year for Chevrolet as a mechanic, and 5 months for Chapman Ford.

FAMILY HISTORY

The defendant does describe a family history of depression in several siblings, including his brother Jay who reportedly attempted suicide. Jay died of HIV in 1994. There is also a family history of alcoholism in the defendant's father, paternal grandfather, and brother Jay. The defendant thinks that his sisters, Kathy and Sheryl, may have taken antidepressants, but he does not know which ones.

The defendant's grandparents are all deceased. His maternal grandfather died of colon cancer, and he believes the others died of "old age."

PAST PSYCHIATRIC HISTORY

The defendant did not receive any psychiatric treatment until after the murder of his wife. He was seen by Joe Mount, M.A. on September 19, 1994, and he followed him over the next two years. He was diagnosed with major depression and noted at times to have suicidal ideation. He was started on imipramine by Dr. Ira Rothstein for depression and remained on this from 9/24/94 to 1/96. He states that the medication initially helped but that he became more bothered by side-effects (dizziness, constipation) and stopped taking it.

He was hospitalized at Middle Tennessee Mental Health Institute for competency to stand trial and criminal responsibility from February 23rd through March 22, 1995. His discharge diagnoses were Alcohol Dependence, Cannabis Dependence, Personality Disorder NOS with Dependent, Passive-Aggressive, and Antisocial Traits. He was seen daily, except on weekends, by a psychiatrist and engaged in the full program. He apparently became angry at the final staffing when the MTMHI failed to agree with his expectation to use the insanity defense. He had reported that he had read in a law book that this defense could be used if he was depressed at the time of the incident. He underwent psychological testing at MTMH, which demonstrated a Full Scale IQ of 85. He was noted to be easily angered, impulsive, deflected blame towards others, and to over-react to minor difficulties. He was seen as having some depressive symptoms, but of note, he was not given a diagnosis of major depression or even dysthymia. He was not diagnosed with intermittent explosive disorder after the 30-day evaluation. He was noted to consistently deflect blame and "did not take responsibility for his difficulties."

He reports having suicidal thoughts after he and his girlfriend broke up in highschool. He states that he had a suicide gesture at that time when "I jumped on my head." He has had intermittent suicidal thoughts while incarcerated.

The patient reports trying alcohol at age 13 and drinking more regularly starting at age 15. He describes his drinking as a teenager as "binge drinking" where he would drink heavily and sometimes pass out. Throughout his marriage, the patient drank regularly – usually having several beers every day. He reports drinking every day, usually 12 beers a day, prior to the death of his wife. He denied any kind of withdrawal symptoms – except " the sweats" – adding that he usually began drinking again when he developed this. The patient began smoking marijuana at the age of 13 and smoked daily after that. He reports that he would smoke marijuana any time that he could get it. He does not smoke tobacco. He tried cocaine in 1990, but spent less than $100 on this. He used LSD more than 50 times, but has not used in years. He denies IVDA, heroin use, PCP, ecstasy, or huffing. He has a history of using Max Alert so he could stay awake to drink.

LEGAL PROBLEMS

1. DUI arrest in 1990
2. Charged with aggravated assault January 1991 after assaulting his wife's boss, Jimmy Kee. The defendant pled to simple assault and was placed on probation. The defendant states that Mr. Kee sold his wife a defective car. Mr. Hall demanded that Mr. Kee return the money and take the car back, and this was in fact done. However, Mr. Hall felt that Mr. Kee was not scheduling his wife for work, as he should. An argument ensued and Mr. Kee reportedly told Mrs. Hall that her husband wasn't "any type of a man and was welcome to get a piece of him." When Billie Hall reported this to her husband, he reportedly drove a mile and badly assaulted Mr. Kee.
3. Defendant was charged 3/10/1994 with aggravated arson and made a plea to reckless burning.
4. Defendant was arrested for possession of marijuana 3/5/94
5. Defendant stole his wife's gun - ? Charges
6. DUI in 1982 and 1991
7. Speeding and Trespassing Charges
8. While living at Hill Court in Huntington, the defendant was charged with disconnecting the outside telephone wires of a neighbor and breaking windows of her apartment and car. Mr. Hall left the state to avoid prosecution and fled to Delaware. He returned to face the charges 8 months later, and he reported that " I beat the case."

EVENTS LEADING TO THE DEATH OF BILLIE HALL

The marriage had endured many stressors including their younger daughter's health problems, marital abuse, the defendant's drug and alcohol problems, and financial problems. During an argument regarding finances, the defendant in March of 1994 lit the couch on fire. He reported to me that he went outside, but returned to the house to help his wife extinguish the fire. One of his children was in the house as the time he started the fire. Mrs. Hall subsequently placed an order of protection after reporting that he assaulted her, disabled the phone, disable the van, and threatened to kill her. Mrs. Billie Hall began divorce proceedings on March 11, 1994 citing inappropriate marital conduct and irreconcilable differences. She requested sole custody of the children with visitation for the defendant, alimony, child support, and a restraining order against the defendant. The latter was granted. The defendant's legal problems continued and he was arrested for possession of marijuana on April 18, 1994 and served 4 days in jail. The patient reportedly became angrier with his wife as he felt he was being manipulated and being sent mixed messages. The defendant reports that she would file an order of protection, but would then call him. Mr. Hall reports that he and Billie were together for the most part during April, May, and June. He reports that they were very short of money

and that Billie was "bitchy." In mid June of 1994, the defendant was changing the oil in a car at work and became angered. He ended up accidentally denting the car and expected to be fire. As a result, he left this job and took the time to visit his brother in Texas who was dying of AIDS. The defendant reports that things were not better when he returned and that his wife was belittling him and calling him a "worthless son of a bitch." He felt that Billie was looking at him with contempt and she allegedly told the defendant that she hated him. Mr. Hall at one point disabled the van so that she could not leave with the kids. Billie Hall filed for a second order of protection citing that he assaulted her and that the defendant had threatened her life. The defendant stated that Billie hit him and he poured beer on her and threw a bottle at her. Mr. Hall reports that his wife was usually the one who was hitting him and not vice-versa. The defendant was again removed from the house. The defendant violated this order of protection when he went to the house on July 7, 1994 to reportedly pick up a check. After being allegedly met at the door by his wife with a gun, he received a police escort to retrieve the check. The defendant at this time was hoping to reconcile with his wife, and called his wife's mother on July 10th to gain her assistance. The defendant later broke into the house and stole the same gun. On July 20, Billie Hall again complained to the police (Officer Stanfill) that the gun had been stolen and that the defendant had threatened her life. The defendant reportedly returned the gun to his wife damaged and unusable on July 23. He reports to me that he "slowed down" the gun by putting rocks and sand into it. He added that he had not wanted a gun around because he had a temper and she had threatened him with it. The defendant's anger increased as he heard that his wife had kissed another man from Billie's daughter. He was also frustrated when he learned that he would only receive $6/ hour working on an assembly line at Columbus-McKinson Chain Factory instead of $14/hour – which is what he thought he would be receiving. On July 28th, Billie Hall met with Officer Stanfill and agreed to press charges against her spouse. DCS became involved with the family after the defendant made reports that the children were left unattended. He later wrote that he hoped by reporting this to DCS that his wife would recognize that she needed him, and they would reconcile.

The state believes that the defendant committed premeditated murder. They cite that defendant's increasing anger and rage at his wife, They have presented evidence that the defendant told an inmate that he intended to inflict serious harm on his wife. In addition, Mrs. Hall had repeatedly told the police her husband had threatened to kill her. Both Darlene Brown and Jackie Brittan told the TBI that the defendant had spoken of making hamburger meat out of his wife. Also, Billie Hall's mother reported that her daughter had said that Jon Hall was going to kill her. The state believes that the defendant cut the phone wires in order to prevent his wife from calling the police. He reportedly forced his way into the house and asked the children to go to their bedrooms. The defendant and his wife entered the bedroom where it appears he blocked the door

with a sewing machine and a vacuum cleaner. There the state reports that he maliciously attacked his wife causing, according to the coroner, at least 83 distinct bruises or injuries. The daughters testified that they were able to force there way into the room where they were briefly able to free their mother. She apparently fled outside, but was caught by the defendant who subsequently dragged her to the children's pool. There, he allegedly strangled her and held her under the water until she died of asphyxiation. The coroner reported that she most likely died of a combination of manual asphyxiation and drowning. Mr. Hall fled the scene in a mini-van, driving on backstreets to avoid capture by the police. He crashed his car, and stole a motorist's car that stopped to offer assistance. He soon discovered that there was a 12-year-old boy in the car, and he released the child. Mr. Hall drove to his brother's home in Belton, Texas where he was quickly apprehended.

According to the defendant, he worked from 7:30 am to 3:30 PM on the day of the murder. He stopped to get a 6 pack of Bush ponies and went to his wife's residence where no one was home. He states that he went to her house to talk about how the meeting with DCS had gone the day before. He left the area around 4:15 PM, went to the home where he was staying (the Brittain's), and that he may have taken a nap. He then went to The Pub in Lexington where he drank beer and had dinner. He went to the Lucky Lady Lounge at 9:15 PM and then on to The BlockHouse at 10 PM. He is not clear how much he drank, but estimates it was at least 12 beers. He reported feeling despondent over the marital problems and he called his wife. He asked to come over, and according to the defendant, she did not refuse. Before knocking on the door, the defendant stated that he looked in the window to see if another man was there. He then disconnected the phone line from the outside. He states that he had done this many times in the past, and he didn't want her to call the police as he was violating an order of protection. He acknowledges that he was breaking a court order. He reported that he knew they would fight. He states that Stephanie let him into the house and that Jenny said, "you're drunk." He was angered by this comment as she had never said anything like this before, and he feared that his wife was "badmouthing" him. He added that he saw a BB gun on the table and this also annoyed him as he felt this was dangerous for the children. The defendant reports that he went to his vehicle to get a money order for child support in the amount of $25. He subsequently asked to sleep on the couch, but Billie refused. He accused her of cheating on him and she allegedly accused him of molesting their daughter, Jessica. Billie reportedly denied having an affair, and Jon Hall reports that he didn't believe her. He doesn't recall tipping her chair, but states that the chairs were cheap, and he could have accidentally put weight on the back. The defendant reports that he followed his wife into the bedroom where she went to smoke a cigarette. She continued to ask him to leave and picked up the phone when he refused. She discovered that it had been disconnected. Mrs. Hall then allegedly asked the defendant if he was going to beat her

like last time. He reports that he flew into a rage and shouted, "Beat you? I'll show you what a beating is!". He then reports that he beat her with his fists 5 or 6 times and yelled to his wife "I'll tell you when it is enough" when she begged him to stop. The defendant reports that he did not block the door with the sewing machine, but that the door hit his foot when the children tried to get in. He states that when he and Billie wanted privacy, they would in the past block the door with the sewing machine – thus that is why he assumes the children thought the door was blocked with that. Eventually the children were able to get in and free their mother. The defendant does not believe that the children bit him and states that the injury attributed to this was old. She fled outside, but was caught shortly thereafter, and the defendant "Karate-chopped" her in the neck. The defendant reports that his wife called for the children to call 911. He shouted "I'll teach you to call 911" and dragged her to the pool where he held her underwater. He released her when a neighbor called out and Billie Hall "gave out." He left her floating in the pool and states that he fled the scene in his wife's mini-van in a panic and without his shoes. He reports taking the backstreets as he felt the police would be coming. He drove into a ditch sometime after midnight. Then, a motorist, William Smith and his wife stopped to offer assistance. The defendant stole their car, which had their 12-year-old son, Clint, in the back. He states that he did not know that the child was in the car until the young man struck him. He states that he pulled over and let the child out of the car. He drove to Brownsville, TN where he pulled into a field and went to sleep. When he woke up, he states he realized that he had committed a carjacking. He then drove on to his brothers where he was arrested 20 minutes after arriving. He reports being surprised to discover that he had killed her.

Of note, he apparently reported to the staff at MTMHI that "I became angry and started thinking if Billie got the divorce she would have control of the kids and the house and Jessie's settlement money." He also reported that he held her in the pool to revive her.

Mr. Hall was initially jailed at the Henderson County Jail from august third to September 13th, 1994. On September 7, 1994, he attempted to escape by using a hacksaw blade on the bars. He was then transferred to Riverbend Maximum Security Institution. The patient does state that he had a small hacksaw given to him by another inmate, but that he believes he was "set up."

AUTOPSY REPORT

The autopsy report demonstrated that Billie Hall died from asphyxia. Dr. Smith wrote, "this 29 year old white woman died as a result of a lack of oxygen arising from compressive forces applied about the neck with a possible contribution of drowning as well." Evidence for manual strangulation included contusions on the neck, hemorrhages in the deep strap muscles, peri-hyoid area, and in the thyroid gland. She also had

conjunctival and visceral petechiae, which one sees with strangulation. In addition, she had multiple lacerations, contusions, and abrasions to the head, face, chest, abdomen, genitals, and extremities. Her nose was fractured. Dr. Smith described the beating as "a very extensive beating."

CORRECTIONAL DISCIPLINARY HISTORY

1. January 19, 1996 - cited for repeatedly hitting a cal light button to complain of being cold.
2. January 20, 1996 – Creating a disturbance
3. February 5, 1996 – cited for assault on staff after head butting Sgt. Hunt and threatening a nurse after she reported he had a self-inflicted wound.
4. February 12, 2001 – Fighting

MENTAL STATUS EXAMINATION

The defendant is a well-developed, well-nourished white male who was well-groomed and wearing prison attire. He did not demonstrate any movement disorders and was without psychomotor agitation, retardation, tics, or tremors. He sat comfortably in his chair, occasionally standing to demonstrate something. He was cooperative with the interview and allowed me to ask the questions and direct the interview. He seemed anxious to report his version of the events and appears to have a good memory for dates and details. His speech was within normal limits in terms of rate, volume, amount, and cadence. He would raise his voice slightly when discussing emotionally laden issues with his attorney. Both his P.I. and his attorney were present. He described his mood as "ok" and he is hopeful that he will get a new trial. He spoke at length of areas he felt previous attorneys had poorly represented him. His affect was generally euthymic and appropriate to content. He did describe suicidal ideation at times, but denied homicidal ideation. His affect was congruent with the subject matter, and at times he appeared to fight back tears. His thoughts were logical and linear. He did not demonstrate any psychotic symptoms whatsoever and was without hallucinations or delusions. He does have some paranoid and narcissistic personality traits. He did not demonstrate or report significant anxiety. He had full control of his behavior. He demonstrated average intelligence. His insight and judgement would be described as poor.

LAB VALUES

HIV test was negative
CT of head was within normal limits
CSF 5-HIAA level was reportedly 70 pM/ml.

PSYCHOLOGICAL TESTING

Please see results performed at MTMHI and by Dr. Pamel Auble.

FORMULATION

At the time of the offense, I believe that Jon Hall demonstrated Alcohol Dependence, Cannabis Dependence, and Personality Disorder, NOS. He has consistently demonstrated personality traits that include Dependency, Passive Aggressive, and Antisocial traits. He describes some depressive symptoms at the time of his wife's death, although I am not convinced he would have met the criteria for Major Depression. He clearly was under stress at the time with financial difficulties, marital difficulties, and ongoing alcohol use. I agree with the treatment team at MTMHI in that I do not believe he has intermittent explosive disorder. The DSM-IV states that this diagnosis can only be made if "the aggressive episodes are not better accounted for by another mental disorder – including antisocial personality disorder- and are not due to the physiological effects of a substance – like alcohol. Mr. Hall has a very long history of sociopathic behavior with failure to conform to social norms with respect to lawful behaviors, deceitfulness, impulsivity and failure to plan ahead, irritability and aggressiveness, reckless disregard for the safety of others, and repeated failures at work. Also, Mr. Hall reported drinking every day for at least a year prior to the event and reported to staff at MTMHI that he would not have killed his wife if he had not been intoxicated. Mr. Hall's aggressive and violent behavior is part of his personality structure. He has a tendency to react violently to perceived rejection – and his only suicide attempt by his report (violence towards himself) came with the breakup with a high school girlfriend.

As for the CSF serotonin level, this is an area of active research and in no means is a diagnostic tool for any psychiatric condition. There are many psychiatric and medical conditions that are believed to be related to low CSF serotonergic activity, and these include but are not limited to schizophrenia, depression, bipolar disorder, malnutrition, sleep disorders, myoclonus, neurological diseases, and many others. The class of antidepressants called selective serotonin uptake inhibitors work by increasing serotonin levels in the neuronal synapses. Also, clozaril, which is used in schizophrenia and bipolar disorder, also affects the serotonergic system. Serotonin is believed to be an integral part of the sleep cycle and can be dysregulated in a variety of sleep problems. As per the DSM-IV, "signs of altered serotonin metabolism have been found in the CSF of some impulsive and temper-prone individuals, but the specific relationship of these findings to Intermittent Explosive Disorder is unclear." There are also multiple articles written on the connection of central serotonin activity and personality disorders. In an article from Neuropsychopharmacology Jan 2002, it states"serotonergic abnormalities may be present in individuals with either substance dependence or antisocial personality disorder." This finding is reiterated in an article from the journal of Experimental and

Clinical Psychoparmacology from 1999. Moreover, there is no indication as to what the CSF serotonin level was at the time of the offense, as this was drawn years later. Since his incarceration, the patient had been diagnoses with major depression and suicidal thoughts – psychiatric symptoms also associated in research with low CSF serotonergic activity.

COMPETENCY TO STAND TRIAL

This defendant is clearly competent to stand trial. He understands the nature of the proceedings against him and is quite able to assist his attorney in his defense.

CRIMINAL RESPONSIBILITY

This defendant was able to appreciate the nature and wrongfulness of his behavior at the time of the offense.

DIMINISHED CAPACITY

The state contends that this was a premeditated killing and the defense maintains that this was an impulsive and unplanned act. It is my opinion based on reviewing the records, evidence, and interviewing the defendant that he was fully capable of premeditation. He was able to engage in complex thought processes that included recognizing the illegality of his behavior and anticipated consequences. This is indicated by his disconnecting the phone wires and by taking a back route when fleeing the scene. Mr. Hall reports that he disconnected the phone wires so his wife wouldn't call the police – not in preparation for a murder. In either case, it demonstrates his ability to recognize that his behavior might lead to the police being called and to plan ahead and prevent that action from being taken. In addition, the coroner reported that there were 83 separate blows or contusions. The time period it must have taken to strike Mrs. Hall this many times, chase her 106 feet, drag her back to the pool, and then strangle her until she lost consciousness indicates an intent to harm and not a sudden and brief explosion. Moreover, Mr. Hall left his wife in the pool with knowledge that she had passed out – again indicating intent to harm. I believe he was able to exercise reflection and judgement of his actions. The defendant does not have a mental disorder that prevents him from premeditation, impulse control, or from recognizing that his conduct was reasonably certain to cause the death of his wife. He was not suffering from a psychiatric illness that would prevent him from exercising reflection, judgement, and control of his actions.

IN THE CIRCUIT COURT OF HENDERSON COUNTY, TENNESSEE
BY
DEPUTY CLERK

STATE OF TENNESSEE)
)
VS.)
)
JON HALL,)

No. 94-342; 94-452
and 94-454

ORDER

This matter came on for hearing on this the _____ day of September, 1996, before the Honorable Whit S. LaFon. After considering the Motion for Change of Venue and Defendant's renewal of the motion for change of venue, the Court finds that the motion is well taken and should be granted. The Court further finds that the venue of the trial should be changed from Lexington, Henderson County, Tennessee to Jackson, Madison County, Tennessee.

IT IS THEREFORE, ORDERED, ADJUDGED AND DECREED that the Defendant's Motion for Change of Venue is well taken and is hereby granted and that the venue of the matter is moved from Lexington, Henderson County, Tennessee to Jackson, Madison County, Tennessee.

Enter, this the 16 day of September, 1996.

WHIT S. LAFON, Judge

APPROVED FOR ENTRY:

AL EARLS
Assistant District Attorney
P. O. Box 2825
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Attorney for Defendant
P. O. Box 1625
Jackson, TN 38302

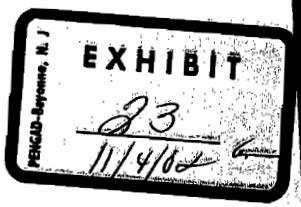
EXHIBIT
11/4/02
PENGAD-Bayonne, N. J.

EXHIBIT 22

Identified and authenticated, this the 18th day of July, 2003.

JUDGE

Impulse-Control Disorders Not Elsewhere Classified



This section includes disorders of impulse control that are not classified as part of the presentation of disorders in other sections of the manual (e.g., Substance-Related Disorders, Paraphilias, Antisocial Personality Disorder, Conduct Disorder, Schizophrenia, Mood Disorders may have features that involve problems of impulse control). The essential feature of Impulse-Control Disorders is the failure to resist an impulse, drive, or temptation to perform an act that is harmful to the person or to others. For most of the disorders in this section, the individual feels an increasing sense of tension or arousal before committing the act and then experiences pleasure, gratification, or relief at the time of committing the act. Following the act there may or may not be regret, self-reproach, or guilt. The following disorders are included in this section:

Intermittent Explosive Disorder is characterized by discrete episodes of failure to resist aggressive impulses resulting in serious assaults or destruction of property.

Kleptomania is characterized by the recurrent failure to resist impulses to steal objects not needed for personal use or monetary value.

Pyromania is characterized by a pattern of fire setting for pleasure, gratification, or relief of tension.

Pathological Gambling is characterized by recurrent and persistent maladaptive gambling behavior.

Trichotillomania is characterized by recurrent pulling out of one's hair for pleasure, gratification, or relief of tension that results in noticeable hair loss.

Impulse-Control Disorder Not Otherwise Specified is included for coding disorders of impulse control that do not meet the criteria for any of the specific Impulse-Control Disorders described above or in other sections of the manual.

312.34 Intermittent Explosive Disorder

Diagnostic Features

The essential feature of Intermittent Explosive Disorder is the occurrence of discrete episodes of failure to resist aggressive impulses that result in serious assaultive acts or

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destruction of property (Criterion A). The degree of aggressiveness expressed during an episode is grossly out of proportion to any provocation or precipitating psychosocial stressor (Criterion B). A diagnosis of Intermittent Explosive Disorder is made only after other mental disorders that might account for episodes of aggressive behavior have been ruled out (e.g., Antisocial Personality Disorder, Borderline Personality Disorder, a Psychotic Disorder, a Manic Episode, Conduct Disorder, or Attention Deficit/Hyperactivity Disorder) (Criterion C). The aggressive episodes are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., head trauma, Alzheimer's disease) (Criterion C). The individual may describe the aggressive episodes as "spells" or "attacks" in which the explosive behavior is preceded by a sense of tension or arousal and is followed immediately by a sense of relief. Later the individual may feel upset, remorseful, regretful, or embarrassed about the aggressive behavior.

Associated Features and Disorders

Associated descriptive features and mental disorders. Signs of generalized impulsivity or aggressiveness may be present between explosive episodes. Individuals with narcissistic, obsessive, paranoid, or schizoid traits may be especially prone to having explosive outbursts of anger when under stress. The disorder may result in job loss, school suspension, divorce, difficulties with interpersonal relationships, accidents (e.g., in vehicles), hospitalization (e.g., because of injuries incurred in fights or accidents), or incarcerations.

Associated laboratory findings. There may be nonspecific EEG findings (e.g., slowing) or evidence of abnormalities on neuropsychological testing (e.g., difficulty with letter reversal). Signs of altered serotonin metabolism have been found in the cerebrospinal fluid of some impulsive and temper-prone individuals, but the specific relationship of these findings to Intermittent Explosive Disorder is unclear.

Associated physical examination findings and general medical conditions. There may be nonspecific or "soft" findings on neurological examinations (e.g., reflex asymmetries or mirror movements). Developmental difficulties indicative of cerebral dysfunction may be present (e.g., delayed speech or poor coordination). A history of neurological conditions (e.g., head injury, episodes of unconsciousness, or febrile seizures in childhood) may be present. However, if the clinician judges that the aggressive behavior is a consequence of the direct physiological effects of a diagnosable general medical condition, the appropriate Mental Disorder Due to a General Medical Condition should be diagnosed instead (e.g., Personality Change Due to Head Trauma, Aggressive Type; Dementia of the Alzheimer's Type, Early Onset, Uncomplicated, With Behavioral Disturbance).

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Prevalence

Reliable information is lacking, but Intermittent Explosive Disorder is apparently rare.

Course

Limited data are available on the age at onset of Intermittent Explosive Disorder, but it appears to be from late adolescence to the third decade of life. Mode of onset may be abrupt and without a prodromal period.

Differential Diagnosis

Aggressive behavior can occur in the context of many other mental disorders. A diagnosis of Intermittent Explosive Disorder should be considered only after all other disorders that are associated with aggressive impulses or behavior have been ruled out. If the aggressive behavior occurs exclusively during the course of a **delirium,** a diagnosis of Intermittent Explosive Disorder is not given. Similarly, when the behavior develops as part of a **dementia,** a diagnosis of Intermittent Explosive Disorder is not made and the appropriate diagnosis is dementia with the specifier With Behavioral Disturbance. Intermittent Explosive Disorder should be distinguished from **Personality Change Due to a General Medical Condition, Aggressive Type,** which is diagnosed when the pattern of aggressive episodes is judged to be due to the direct physiological effects of a diagnosable general medical condition (e.g., an individual who has suffered brain injury from an automobile accident and subsequently manifests a change in personality characterized by aggressive outbursts). A careful history and a thorough neurological evaluation are helpful in making the determination. Note that nonspecific abnormalities on neurological examination (e.g., "soft signs") and nonspecific EEG changes are compatible with a diagnosis of Intermittent Explosive Disorder and only preempt the diagnosis if they are indicative of a diagnosable general medical condition.

Aggressive outbursts may also occur in association with **Substance Intoxication** or **Substance Withdrawal,** particularly associated with alcohol, phencyclidine, cocaine and other stimulants, barbiturates, and inhalants. The clinician should inquire carefully about the nature and extent of substance use, and a blood or urine drug screen may be informative.

Intermittent Explosive Disorder should be distinguished from the aggressive or erratic behavior that can occur in **Oppositional Defiant Disorder, Conduct Disorder, Antisocial Personality Disorder, Borderline Personality Disorder,** a **Manic Episode,** and **Schizophrenia.** If the aggressive behavior is better accounted for as a diagnostic or associated feature of another mental disorder, a separate diagnosis of Intermittent Explosive Disorder is not given. Aggressive behavior may, of course, occur when no mental disorder is present. **Purposeful behavior** is distinguished from Intermittent Explosive Disorder by the presence of motivation and gain in the aggressive act. In forensic settings, individuals may **malinger** Intermittent Explosive Disorder to avoid responsibility for their behavior.

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Diagnostic criteria for 312.34 Intermittent Explosive Disorder

A. Several discrete episodes of failure to resist aggressive impulses that result in serious assaultive acts or destruction of property.

B. The degree of aggressiveness expressed during the episodes is grossly out of proportion to any precipitating psychosocial stressors.

C. The aggressive episodes are not better accounted for by another mental disorder (e.g., Antisocial Personality Disorder, Borderline Personality Disorder, a Psychotic Disorder, a Manic Episode, Conduct Disorder, or Attention-Deficit/Hyperactivity Disorder) and are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., head trauma, Alzheimer's disease).

312.32 Kleptomania

Diagnostic Features

The essential feature of Kleptomania is the recurrent failure to resist impulses to steal items even though the items are not needed for personal use or for their monetary value (Criterion A). The individual experiences a rising subjective sense of tension before the theft (Criterion B) and feels pleasure, gratification, or relief when committing the theft (Criterion C). The stealing is not committed to express anger or vengeance, is not done in response to a delusion or hallucination (Criterion D), and is not better accounted for by Conduct Disorder, a Manic Episode, or Antisocial Personality Disorder (Criterion E). The objects are stolen despite the fact that they are typically of little value to the individual, who could have afforded to pay for them and often gives them away or discards them. Occasionally the individual may hoard the stolen objects or surreptitiously return them. Although individuals with this disorder will generally avoid stealing when immediate arrest is probable (e.g., in full view of a police officer), they usually do not preplan the thefts or fully take into account the chances of apprehension. The stealing is done without assistance from, or collaboration with, others.

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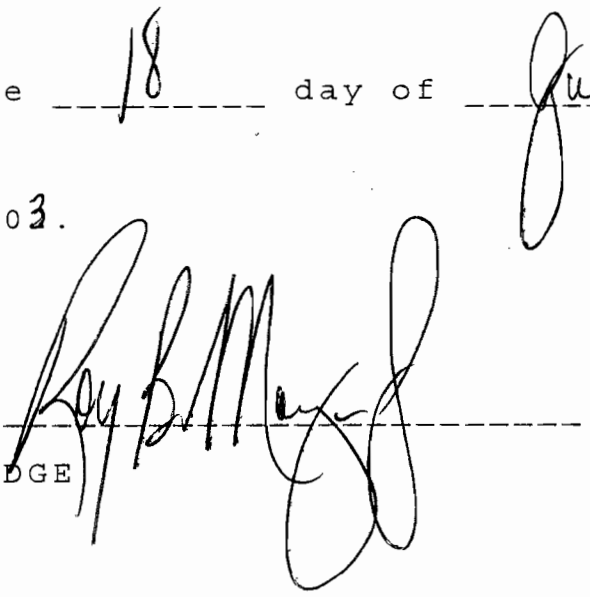
EXHIBIT 23

Identified and authenticated, this the 18 day of July, 2003.



JUDGE

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EXHIBIT
Coll. 24
11/4/02

CURRICULUM VITAE

Kimberly Frances Stalford

Current Address
1771 Madison Street
Clarksville, TN 37043

EMPLOYMENT HISTORY:

Consulting Psychiatrist to Gateway Hospital providing in-patient psychiatric consultations, evaluations, and treatment – March 2002 to present.

Attending Psychiatrist at Tennessee Christian Hospital's Psychiatric Unit at Gateway Health System, Clarksville, TN - April 2000 to January 31, 2002

Out-Patient Psychiatrist at the Clarksville Family Guidance Center, Clarksville TN - October 1998 to December 1999

Attending Psychiatrist at Sheppard and Enoch Pratt at Cockeysville - Community Mental Health Center, Baltimore, MD - July 1, 1996 to June 1, 1998.

EDUCATION:

American Board of Psychiatry and Neurology Part I- Passed November 1996, 97th percentile rank (Psychiatry Major)
Part II- Passed with Board Certification May, 1997

RESIDENCY, Sheppard and Enoch Pratt Hospital, Baltimore, MD
Chief Resident - July 1995 - June 1996
Completed a fully accredited, four year General Psychiatry Program June 30, 1996

M.D., University of Virginia School of Medicine
Charlottesville, VA
August 1988 - May 1992

B.A., Wesleyan University
Middletown, CT
August 1984 - May 1988
Major: Molecular Biology and Biochemistry

HONORS/AWARDS:

The 1996 Pfizer Psychiatric Resident of the Year in recognition of outstanding academic and clinical achievement in the field of psychiatry
Alpha Omega Alpha
Janet M. Glasgow Memorial Achievement Citation - Awarded by the American Medical Women's Association for Scholastic Achievement at the University of Virginia School of Medicine

Teaching Excellence Award, University of Virginia School of Medicine
Phi Beta Kappa
National Honor Society

RESEARCH EXPERIENCE:

Utilization of Monoclonal Antibodies to Dengue Virus for Rapid Diagnostic Assay.
J. Opprandy, Ph.D., Director of Naval Medical Research Institute - Biotechnology Division, National Naval Medical Center, Bethesda Md.
Abstract presented at Annual Meeting of American Society of Tropical Medicine, 1989.

Effect of Unilateral Lesioning of the Ventromedial Tegmentum on the Isolation-Induced Fighting of Male Rats.
Advisor: D. Adams, Ph.D., Professor of Psychology, Wesleyan University, 1986.

Effects of Estrous and Hunger on Isolation-Induced Fighting of Female Rats.
Advisor: D. Adams, Ph.D., Professor of Psychology, Wesleyan University, 1986.

PROFESSIONAL SOCIETY MEMBERSHIPS:

American Medical Association
American Psychiatric Association
Tennessee Psychiatric Association

EXTRACURRICULAR ACTIVITIES:

Sheppard and Enoch Pratt Health System:

Resident Representative on Committee evaluating establishment of centralized admission and crisis unit.
Resident Representative on Committee evaluating discharge planning
Residency Training Advisory Committee.

University of Virginia School of Medicine:

Mulholland Society Council (Medical Student Government)
Tutor for the Office of Academic Support
Member of Share (Community Volunteer Organization)

COLLECTIVE EXHIBIT 24

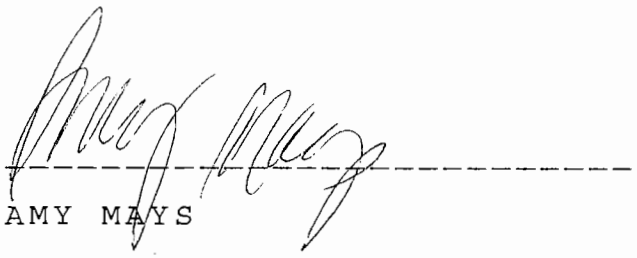
Identified and authenticated, this the 18th day of July, 2003.

_____
JUDGE

CERTIFICATE

I, the undersigned Amy Mays, Official Court Reporter for the 26th Judicial District of the State of Tennessee, do hereby certify that the foregoing is a true, accurate and complete transcript, to the best of my knowledge and ability, of the requested proceedings had in the captioned cause, in the Criminal Court for Madison County, Tennessee, on the 4th day of November, 2002.

I do further certify that I am neither of kin, counsel nor interest to any party hereto.



AMY MAYS

November 18, 2002

DATE

CERTIFICATE OF THE COURT

THIS IS TO CERTIFY THAT THE TRANSCRIPT OF EVIDENCE ADDUCED AT THE HEARING OF THIS CAUSE HAS BEEN FILED WITH THE CLERK OF THE COURT.

The Court has examined this Transcript of Evidence and has found it to be a true and accurate record of the proceedings.

Therefore, it is Ordered, Adjudged and Decreed that the Transcript of Evidence is hereby approved by the Court and will be part of the record on appeal in this case.

_____
JUDGE

July 18, 2013
_____
DATE

APPROVAL:

_____
ATTORNEY FOR THE PETITIONER

_____
ATTORNEY FOR THE STATE